Results: 207 questionnaires were completed over a 2-week period of data collection in two NHS sites. Mean waiting time (min): 28.92 (s.d. 18.64). Patient satisfaction recorded: Very satisfied (123/207, 59.4%), Satisfied (66/207, 31.9%), Neutral (15/207, 7.2%), Unsatisfied (1/207, 0.5%), Very Unsatisfied (2/207, 1.0%). 187 (90.3%) patients found the waiting time acceptable and felt they had sufficient consultation time in clinic. There was a weak correlation between waiting time and patient satisfaction ($r = -0.284$, $p < 0.001$) on Spearman's Rank Correlation.
Conclusions: The results of this audit suggest that patient satisfaction may be influenced by adequate time spent with the clinician during their appointment rather than overall waiting times. Good communication skills and thorough consultation by clinicians are pivotal in ensuring patient satisfaction in this area.

1337: PERIOPERATIVE MANAGEMENT OF PAEDIATRIC OBSTRUCTIVE SLEEP APNOEA

Elizabeth Vaughan [1], Donald Urquhart [2], Mary-Louise Montague [1], Nicola Stirrat [1], David Fynn [2], Alok Sharma [1]. [1] *Department of ENT Surgery, The Royal Hospital for Sick Children, Edinburgh, UK;* [2] *Department of Paediatric Respiratory and Sleep Medicine, The Royal Hospital for Sick Children, Edinburgh, UK.*
Aim: Polysomnography (PSG) is the gold standard for diagnosing Obstructive Sleep Apnoea (OSA). In the UK the diagnosis and decision to proceed to adenotonsillectomy is usually clinical as PSG is not widely available. The Sleep Service at our centre provides limited-channel cardiorespiratory sleep studies (SS) for children with suspected OSA. This affords categorisation of OSA severity and informs the need for a high dependency unit (HDU) bed post-operatively. This audit reviews SS outcomes at our centre and their impact on operative management and use of HDU beds.
Method: Retrospective analysis of non-syndromic children without co-morbidities who had limited-channel cardiorespiratory SS at our centre from January 2009 to December 2012.
Results: 271 children were included. In 45% (n=121) SS showed no evidence of OSA. 30% of all children (n=80) did not proceed to adenotonsillectomy on this basis. Of 191 children undergoing adenotonsillectomy, SS informed a request for a HDU bed in 17 (8.9%). Only 5 children (2.6%) had post-operative airway sequelae which warranted HDU care.
Conclusion: Cardiorespiratory sleep studies appears to help avoid unnecessary surgery in 30% of children. This requires further analysis. The low rate of airway sequelae suggests HDU care is probably only indicated in cases of severe OSA.

1360: ENT JUNIOR DOCTORS NATIONAL SURVEY – OPINIONS ON EMERGENCY CARE

Raguwinder Singh Sahota, Vishnusai Chauhan, Peter John Conboy, Farakh Javed Uddin. *Leicester Royal Infirmary, Leicester, UK.*
Aim: A telephone survey of all English hospitals providing an emergency ENT service to identify the provision of emergency department (ED) dedicated treatment areas and junior doctors' opinions regarding dedicated ENT facilities within the ED.
Method: A database of all hospitals in England that provided an ENT service (319 hospitals) was compiled using the NHS direct website and the junior doctor team contacted. The type of service provided at each hospital was determined - emergency service (124), outpatient only (141) or private hospital (54).
Results: 119/124 (96.0%) hospitals had an out of hours treatment room. However, only 26 (21.0%) hospitals had a treatment room situated in the ED. 97/124 (78.2%) junior ENT doctors thought it would be in the patient's best interest to have an ENT treatment room within the ED and 90/124 (72.6%) thought that patient treatment would improve with a dedicated ED ENT treatment room.
Conclusion: We recommend a dedicated ENT treatment room available at all times for emergency patients and ideally situated within the ED to aid in the management of ENT emergencies.

1444: IS THERE A NEED FOR TRAINING IN ENT EMERGENCY CLINIC TRIAGE?

Neil Foden, Matthew Ellis, Mahmood Bhutta, Penny Lennox. *John Radcliffe Hospital, Oxford, UK.*
Aim: Triage of referrals can be difficult. Our aim is to discover whether there is variation in the triage of referral letters to the emergency ENT clinic between individuals of various grades of staff and assess for consistency of triage for conditions.
Methods: 100 sequential referral letters to the ENT emergency clinic were assessed by all participants in an ENT department (doctors and clinic nurses). Referral letters were triaged to either the ENT emergency clinic (see within 24 hours, 72 hours or 1 week) or the elective clinic (to be seen "urgently", "soon" or "routinely").
Results: 27 members of the department triaged 100 letters each (3 nurses, 6 SHOs, 8 SpRs and 10 Consultants). There was a good overall level of agreement (0.931, $p < 0.0001$) amongst all grades. Nurses had the lowest level of agreement (0.454, $p < 0.0001$). The lowest levels of agreement for triaging a condition were epistaxis (0.416, p=0.009), facial nerve palsy (0.442, p=0.037) and nasal foreign bodies (0.384, p=0.056).
Conclusion: The triage of referral letters to an ENT emergency clinic varies between members within the department but overall there is good agreement. Training may help to improve triage services for certain conditions across all grades.

1451: A PATIENT SATISFACTION SURVEY FOLLOWING MUA NOSE: SHOULD WE BE DOING THEM?

Neil Foden, Matthew Ellis, Florence Hogg, Theo Joseph. *Royal National Throat, Nose and Ear Hospital, London, UK.*
Aim: Nasal fractures are seen commonly in ENT urgent referral and outpatient clinics. Closed reduction or manipulation under anaesthetic (MUA) of a fractured nose is performed for functional or cosmetic reasons. We sought to ascertain patient satisfaction following MUA nose.
Methods: A retrospective review of all adults who underwent MUA nose for nasal fractures at a single centre over an 18-month period (December 2010-May 2012) was undertaken. A structured interview was carried out by a single interviewer.
Results: 106 patients out of 151 patients were successfully contacted (70.2%). There were 75 males (70.8%). Cause of trauma included assault (42%), sport (33%) and accidental/fall (25%). 93% were consented for failure of outcome of MUA. 45 (42%) would consider further surgery following their MUA. Independent risk factors for patients wanting further surgery were previous sinonasal surgery and breathing symptoms (OR 3.983, $p < 0.02$).
Conclusion: MUA for fractured nose is an acceptable treatment in the first instance and should be attempted, but a number of patients may be dissatisfied. 42% would consider revision surgery which has consequences for funding. It is essential that all patients undergoing MUA following a nasal fracture are consented for failure and that revision surgery may be required.

1471: GUM TRAUMA AFTER ENDOSCOPIC EXAMINATION IN HEAD AND NECK PATIENTS – IS A WET SWAB ENOUGH?

Shi Ying Hey, Anna Harrison, Kenneth MacKenzie. *Department of Otorhinolaryngology-Head and Neck Surgery, Glasgow Royal Infirmary, Glasgow, UK.*
Per oral rigid endoscopic procedures are widely used diagnostic and therapeutic tools in head and neck pathology. Dental protection is routinely used to cushion the upper dentition from endoscopic instruments in order to minimise iatrogenic injuries. Incidence of oral trauma due to rigid endoscopes and the effectiveness of protection appliances were investigated.
Methods: A review was conducted of prospective data collected on endoscopic procedures performed between July and December 2012. Dentition integrity was assessed pre- and post- operatively.
Results: Eighty-one patients were included during the study period (48M: 33 F). Of these patients, 54 (66.7%) had saline-soaked gauze for gum protection, 21 (25.9%) had ?mediguard, and 6 (7.4%) had custom-made mouth-guards.
Overall incidence of post-endoscopic alveolar mucosa injury was 23.5% (19/81). All 19 patients with gum injuries were in the gauze subgroup. Of these, 7 were edentulous, 7 had partially or fully edentulous upper ridge, 1 had fully edentulous lower ridge and 4 were completely dentate. No teeth trauma was recorded.
Conclusion: Dental injury remains significant during rigid endoscopic procedures. Wet gauze does not appear to provide sufficient dental